

Patient \_\_\_\_\_ Account # \_\_\_\_\_

I hereby authorize payment to Kemmler Orthopaedic Center for services rendered and billed to me.

I authorize release of medical information for insurance purposes.

I understand that I am responsible for all charges related to my treatment. This includes all services not covered by insurance or for charges not paid because they are deemed more than the "usual and customary" rates as determined by my insurance carrier.

I understand that all charges are due and payable within ninety (90) days from the date of service regardless of my insurance coverage so long as any services which will be submitted to Medicare or Medicaid have not been assigned to Kemmler Orthopaedic Center, Inc. I understand this includes commercial, workers' compensation or liability coverage.

If a workers' compensation claim is denied, we reserve the right to file your charges with your group carrier.

I authorize the use of this form on all bills from this office.

A Xerox copy is as good as any original on bills from this office.

Signature \_\_\_\_\_

Date \_\_\_\_\_